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ERRATUM

Erratum to: Malignant melanoma: factors affecting the surgical interval from excision biopsy to definitive surgical management

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The original version of the article has been published with few errors. The corrected text is given below:

- The final sentence of paragraph 1 of the Introduction should read: The other two studies [5, 6], both from the United States, investigated the same relationship and whilst they found similar outcomes, they did notice a **small non-significant** correlation between an increasing SI and reduced overall and disease-free survival.
- Sentences 1 and 2 from paragraph 1 of the Methods should read: A retrospective review of a prospectively maintained database including all adult patients diagnosed with primary invasive cutaneous malignant melanoma who underwent a DEB followed by a WLE between January 2010 and June 2011 within a **secondary and** tertiary referral centre was performed. Demographic data, clinico-pathological characteristics of the malignant lesions, **as well as lentigo maligna lesions**, and staging investigations were recorded.
- The final sentence of paragraph 1 of the Results should read: **Diagnostic Excision Biopsies** of malignant melanoma were most commonly performed by a dermatologist ($n = 47$, 43.9 %) followed by the general surgeons ($n = 31$, 29 %) and plastic surgeons ($n = 21$, 19.6 %).
- Paragraph 4 of the Results should read: The majority of melanomas were located on the limbs (lower > upper limbs) followed by the face and the back (Table 1). Dermatologists performed the majority of DEBs involving the face (57.14 %) with plastic and general surgeons performing 42.85 and 4.76 % respectively. General surgeons were more likely to excise more aggressive lesions on the trunk and limbs with the average rate of mitoses in this group being 8.66/mm^2 compared with mitotic rates of 4.28 and 4.21/mm^2 in the plastic surgery and dermatology groups respectively. **There was no significant difference between groups with regard to Breslow thickness of the lesions excised**. The anatomic location of the lesion predicted the SI, with lesions of the head and neck undergoing WLE 48 ± 32.3 days after DEB compared with 37.5 ± 22.6 days for all other sites ($p = 0.001$).
- The third sentence of paragraph 1 of the Discussion should read: The incidence of melanoma in Ireland is amongst the highest in the European Union which is likely to be multi-factorial in nature, with Ireland having predominantly lighter skin types as well as relatively poor social awareness **and the poorest access to Dermatology services in Europe**.
- The third sentence of paragraph 2 of the Discussion should read 'British **Association** of Dermatology' and not 'British Society of Dermatology'.

The online version of the original article can be found under doi:10.1007/s11845-014-1157-5.

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- Few sentences of paragraph 5 of the Discussion should read: The longer SI is likely explained by the fact that many of these cases were subsequently referred to a plastic or general surgeon especially where there was a larger, more aggressive or cosmetically challenging lesion requiring a more invasive or complex WLE. **The inclusion of lentigo maligna lesions within the cohort is also likely to account for the significant difference between the two groups**. It is interesting that general surgeons were more likely to be involved from an early stage in lesions with a high mitotic rate as shown by the fact that the average mitotic rate of lesions in cases where the general surgeon performed the DEB was 8.66/mm^2 compared to 4.21/mm^2 in cases where the DEB performed by a dermatologist. **Again, the inclusion of lentigo maligna lesions within the cohort contributes significantly to this difference**. It is likely that referral patterns in aggressive cases…
- Abbreviations list:

DEB	Diagnostic excision biopsy
SI	Surgical interval
WLE	Wide local excision
OS	Overall survival
DFS	Disease free survival